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THE IMPACT OF BEHAVIORAL HEALTH ISSUES ON SOLDIERS RETURNING FROM DEPLOYMENT – ASSESSING THE PROGRAMS FOR REINTEGRATION OF SOUTH CAROLINA NATIONAL GUARD SOLDIERS

BY

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The National Guard, from its inception, has drawn Soldiers from all walks of life to defend the nation from threats at home and abroad. The Guard's unique structure creates significant challenges for leaders when facing critical issues concerning reintegration. The unprecedented deployments have had a significant impact on the force. The combined stress of multiple deployments, extended separation from family, and serving on an asymmetric battlefield have resulted in Soldiers experiencing a variety of behavioral health issues to include Post Traumatic Stress Disorder (PTSD). The significant reintegration issues that we face requires leaders at all levels of the National Guard to actively engage Soldiers on a more routine and personal basis to better understand the struggles they face in order to assist them in getting the care they need. The South Carolina National Guard (SCNG) State Family Programs and the South Carolina Law Enforcement Assistance Program (SCLEAP) are working together to conduct Post Deployment Seminars for Soldiers who have returned from deployment and are experiencing issues adjusting back to civilian life. This paper is to evaluate the objectives and assess the SCNG State Family Programs to determine if changes should be made to the program.

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The National Guard, from its inception, has drawn Soldiers from all walks of life to defend the nation from threats at home and abroad. The Guard's unique structure creates significant challenges for leaders when facing critical issues concerning reintegration. The unprecedented deployments have had a significant impact on the force. The combined stress of multiple deployments, extended separation from family, and serving on an asymmetric battlefield have resulted in Soldiers experiencing a variety of behavioral health issues to include Post Traumatic Stress Disorder (PTSD). The significant reintegration issues that we face requires leaders at all levels of the National Guard to actively engage Soldiers on a more routine and personal basis to better understand the struggles they face in order to assist them in getting the care they need. The South Carolina National Guard (SCNG) State Family Programs and the South Carolina Law Enforcement Assistance Program (SCLEAP) are working together to conduct Post Deployment Seminars for Soldiers who have returned from deployment and are experiencing issues adjusting back to civilian life. This paper is to evaluate the objectives and assess the SCNG State Family Programs to determine if changes should be made to the program.

TABLE OF CONTENTS

THE IMPACT OF BEHAVIORAL HEALTH ISSUES ON SOLDIERS RETURNING FROM DEPLOYMENT – ASSESSING THE PROGRAMS FOR REINTEGRATION OF SOUTH CAROLINA NATIONAL GUARD SOLDIERS

Introduction

The decade following the tragic events of 9/11 has significantly impacted the country and defined the lives and careers of those who serve in our armed forces. The initial response to protect our homeland saw the rapid mobilization and deployment of Guardsmen nationwide. Unforeseen then, the Nation continues to be intensely involved in the War on Terrorism. The commitment of manpower alone is staggering. Since 9/11 more than 462,000 Army and Air National Guard Soldiers have been mobilized for federal (Title 10) duty to support Overseas Contingency Operations around the world.[1]

Like warriors from all branches of service, many Guardsmen are returning home from the battlefield only to find themselves struggling on another front. Stress from multiple deployments, separation from family, and serving on an asymmetric battlefield leaves many Soldiers struggling with behavioral health issues to include Post Traumatic Stress Disorder (PTSD). "Depending on the level of combat intensity, a number of studies involving OIF and OEF Warriors have shown that between 10 to 20 percent experience a sufficient number and severity of symptoms to be considered to have PTSD within a year after returning home".[2] In addition to the prevalence of PTSD, the number of suicides is unprecedented. These issues come as no surprise, in fact "The Department of Defense (DoD) and Department of Veterans Affairs (VA) acknowledged at the beginning of the wars in Afghanistan and Iraq that there would be substantial psychological cost".[3]

The intent of this paper is to address issues that impact National Guard Soldiers following deployment that hinder their ability to successfully reintegrate back to civilian life. The initial

focus is on the impact of behavioral health issues to include Post Traumatic Stress Disorder (PTSD), on National Guard Soldiers and their families. This is followed with a general overview of the South Carolina National Guard (SCNG) Family Care Programs' missions and objectives; with specific emphasis on the Post Deployment Seminar (PDS) to determine whether the program provides significant benefit to Soldiers in the reintegration process to warrant continued support as part of the SCNG "continuum of care" and assistance.

The National Guard as an Operational Force

Since its first Muster in 1636 "citizen-soldiers" of the National Guard have come from all walks of life to defend the Nation from threats at home and abroad. As a community-based force, the National Guard "brings a deep connection to the population because of its geographic dispersion in over 3,000 communities across the nation."[4] Authorization for the National Guard to perform duel role missions is established by United States Code, Title 32 for State missions and Title 10 for Federal missions. These missions require the National Guardsmen be trained for domestic emergencies as well as available for prompt mobilization in support of Overseas Contingency Operations (OCO). The motto *"Always Ready, Always There"*[5] embodies the mission and spirit of the National Guard.

In the Cold War era the Reserve Component (RC) traditionally operated as a *force in reserve* to augment the Active Component (AC) in combat support or combat service support. In this scenario "the mobilization lead time would likely be months, not weeks or days."[6] The extended time frame from mobilization to deployment allowed the Soldier and the family more opportunities to prepare for extended separation. The initial concept of the RC serving in a dual role with operational and strategic missions came about in the first Gulf War in 1990-1991. Based on the expected Operational Tempo (OPTEMPO) a large number of Reserve Forces

(267,300) mobilized for full spectrum operations alongside their Active Component counterparts.[7] Although the impact of the mobilization was relatively minimal on Soldiers, families, and their employers due to the short duration; the performance of the mobilized forces proved their effectiveness in an operational role. Perhaps a more significant outcome from the mobilization was the widespread support of the American public that was generated in part by the large scale mobilization of the Reserve Component (RC). The importance of having the support of the American people was noted by former Chief of Staff of the Army; General Creighton Abrams following the war in Vietnam when he

> asserted his belief that the American armed forces must not go to war again without calling up 'the spirit of the American people' which meant calling up the National Guard and Reserve. By involving the Guard and Reserve, the will of the people is brought to the fight.[8]

The National Guard is fully engaged in the Global War on Terrorism (GWOT) with more than "60,000 Army and Air National Guard personnel supporting expeditionary operations around the world, including Operations Enduring Freedom and Iraqi Freedom."[9] OPTEMPO to meet world-wide contingencies led to the implementation of the Army Force Generation (ARFORGEN) model in 2006 and later to the Department of Defense Directive 1200.17, "Managing the Reserve Components as an Operational Reserve" in October 2008. As noted by Major General Raymond Carpenter, Acting Director of the Army National Guard, "Consistent accomplishments of ARNG soldiers have brought the operational force to life."[10] Further, as noted in the *2011 Army Posture Statement*, "The critical contribution of the Army's Reserve Component (Army National Guard and the Army Reserve) to supply-based ARFORGEN is fundamental to meeting our Nation's security requirements and re-establishing operational depth and strategic flexibility."[11] Although the model enables the Army (AC and RC) to meet mission requirements, the originally envisioned purpose of a "supply-based model", has not been fully realized due to mission requirements exceeding the sustainable supply.[12] The current model is based on three force pools, *RESET, TRAIN/READY, and AVAILABLE* with each pool having a specific end-state

for preparing units for deployment or future contingencies. A significant factor that impacts the force pool continuum is "boots on the ground" (BOG) time to dwell time ratio (time deployed verses time at home) between deployments. Due to mission requirements, at the height of the war in Iraq AC forces deployed for fifteen months and were at home for one year.[13] Although the goal for the National Guard was a 1:4 BOG / dwell ratio, mission requirements dictated that some units had to deploy on a more frequent basis with an average of 1:2 to 1:3 BOG / dwell ratio.[14] The 2011 Army Posture Statement notes the current interim BOG / dwell ratio goal is 1:2 AC and 1:4 RC; and will "examine the cost and benefits of increasing dwell to 1:3 and 1:5 respectively with a nine month Boots on the Ground Policy."[15]

Challenges faced by the National Guard with Reintegration of Soldiers

The OPTEMPO to support a decade of combat operations in two Theaters is resulting in a significant transformation for the Guard. As noted by Major General Carpenter "Nearly 60 percent of the Soldiers in the Army National Guard wear a right shoulder patch and are veterans of Operation Iraqi Freedom, Operations New Dawn or Operation Enduring Freedom."[16] Multiple deployments, extended separation from family, exposure to traumatic events on the battlefield have all lead to issues that make successful transition back to civilian life challenging for all. The most identifiable issues that NG Soldiers face include:

- Behavioral health issues stemming from traumatic incidents while deployed,
- Family issues attributed to extended periods of separation or other factors,
- Employment issues,
- Limited ability of unit leadership to observe/monitor the behavior/activity of Soldiers,
- Soldiers accessing timely and convenient mental health care,
- The cumulative effects of all matters related to the deployment process; and
- Over-coming issues related to "stigma" that impedes Soldiers seeking help.

Though all of these issues are cause for distress, of greatest concern is the growing number of behavioral health issues and the impact these issues can have in every aspect of a Soldier's life. These *behavioral health* issues encompass a variety of disorders to include stress, depression, anxiety, alcohol or substance abuse (both legal and illegal), post-traumatic stress disorder (PTSD), and unfortunately suicide. The cause of some of these disorders can be directly linked to exposure to *traumatic* events in combat. However, some develop from the *cumulative* effect of remaining in a physically and mentally alert mode for extended periods of time; whereas some issues derive from the *gradual* effects related to multiple and extended deployments.

While deployed, servicemen are part of a team that live and work together and depend on each other to perform their mission; missions that provide camaraderie, focus of effort, and a sense of accomplishment. These important factors when coupled together form the core elements necessary to achieve mission success and survive in difficult and dangerous situations. The same is true on returning home; "work provides meaning and gratification in one's life, and is one of the most important components of successful readjustments to civilian life."[17]

Employment issues (unemployed or under-employed) linked to the depressed economy is resulting in financial difficulties for a number of Guardsmen. A research article published in the Journal of Traumatic Stress notes from their research sample (Active duty deployed n=670 / National Guard deployed n=104) "over 20% of National Guard, compared with < 1% regular active duty Soldiers faced unemployment when they returned".[18] Although there is no data that directly links multiple deployments to adverse economic conditions, over 31% of South Carolina Guardsmen have deployed more than once since 9/11. The Mental Health Advisory Team (MHAT) created in 2003 to assess behavioral health of Soldiers in theater, continuously identifies multiple deployments as risk factors for psychological problems. The MHAT VI

(OEF) specifically reports that "Three-plus times deployers are significantly more likely to meet the criteria for a psychological problem (31%) than are first (13.6%) or second time (18.1%) deployers".[19] Overall the MHAT (OIF) and (OEF) studies underscore the cumulative impact that multiple deployments have on Soldiers and serves notice that the problems will continue to manifest based on OPTEMPO.

The intent of the ARFORGEN model is to track the mobilization cycle of units, not individual Soldiers. The model can be modified to meet mission demands and allows individual Soldiers to volunteer for additional active duty/deployments. As outlined in a document published in 2008 by the Office of the Assistant Secretary of Defense for Reserve Affairs, "The expanded operational use of the Guard and Reserve is built on a construct of voluntary service, in which Guard and Reserve members are able to serve more frequently or for varying periods to support operational missions."[20]

Behavioral Health Issues and their Impact

A substantial collective effort is being made by the DoD, Army (AC and RC), Veterans Administration, and other governmental and private organizations to address the "invisible wounds of war". The resources available represent the efforts of distinguished professionals from both the medical and psychological fields of medicine. In 2010 Thomas J. Berger, Ph.D. Executive Director, Veterans Health Council Vietnam Veterans of America gave a presentation titled "Mental Health for Military Families: The Path to Resilience and Recovery" and he notes,

> There is evidence that the high rates of trauma experienced by those stationed in the Southwest Asia theaters will result in increased demands" on private and military health care systems. He further states, "As the number of OIF/OEF veterans grows, their continued care is a national health care concern.[21]

As we soon enter the second decade of war in Iraq and Afghanistan it is evident that the total cost to our military and Nation greatly exceeds the "dollars" needed to fund combat,

stability, and nation building efforts. As of April 30, 2011, 6,010 of our Nations sons and daughters have paid the *ultimate pri*ce in service to our country in Iraq and Afghanistan.[22] The service and sacrifice made by these Warriors and the millions of others who have selflessly served our country should forever he honored by a grateful nation.

To treat the "invisible wounds of war" of our Soldiers we are faced with other significant challenges that extend beyond the costs in dollars — quality of life issues. The RAND Corporation conducted a study of service members (inclusive of all branches and components) who served in either Operations Iraqi Freedom or Enduring Freedom and found that "18.5% of all returning servicemembers meet criteria for either PTSD or depression; 14% of returning servicemembers currently meet criteria for PTSD, and 14% meet criteria for depression."[23] It is imperative that Soldiers having conditions such as PTSD and depression receive proper treatment or face significantly higher risks for other behavioral health issues to include psychological problems and suicide, other unhealthy life style issues "such as smoking, overeating, and unsafe sex — and higher rates of physical health problems and mortality."[24] These conditions adversely impact marriage, home life, employment, and are possibly linked to homelessness.

To determine the costs associated with PTSD and depression, researchers used a method of micro simulation to project two-year costs — costs incurred within the first two years after servicemembers return home. For this application

> a microsimulation model takes a hypothetical group of simulated individuals and predicts future cost-related events, allowing the simulated population to experience mental conditions, mental health treatment, and secondary outcomes, such as employment. An advantage of the microsimulation approach is that it treats mental disorders as chronic conditions, allowing for both remission and relapse over time. In addition, the microsimulation model can be useful for evaluating different policy scenarios. In our case, we are particularly interested in

> asking the policy question: 'If we increase the use of evidence-based treatment, will we save money in the long run?'[25]

A cost per-case for PTSD, Major Depression, and Co-morbid PTSD and Depression, and the number of Soldiers estimated to have conditions of PTSD and depression (estimated from the 1.6 million troops deployed since 2001) was used to predict the two-year cost for treatment. Based on this calculation the

> two-year costs associated with PTSD are approximately $5,904 to $10,298, depending on whether we include the cost of lives lost to suicide. Two-year costs associated with major depression are approximately $15,461 to $25,757, and costs associated with co-morbid PTSD and major depression are approximately $12,427 to $16,884….based on these parameters it is estimated that PTSD-related and major depression-related costs could range between $4.0 and $6.2 billion over two-years (in 2007 dollars)[26]

These estimates for the first two years represent only a portion of the cost and do not begin to include costs potentially associated with "substance abuse, domestic violence, homelessness, family strain, and other factors, thus understating the true costs associated with deployment-related cognitive and mental health conditions."[27]

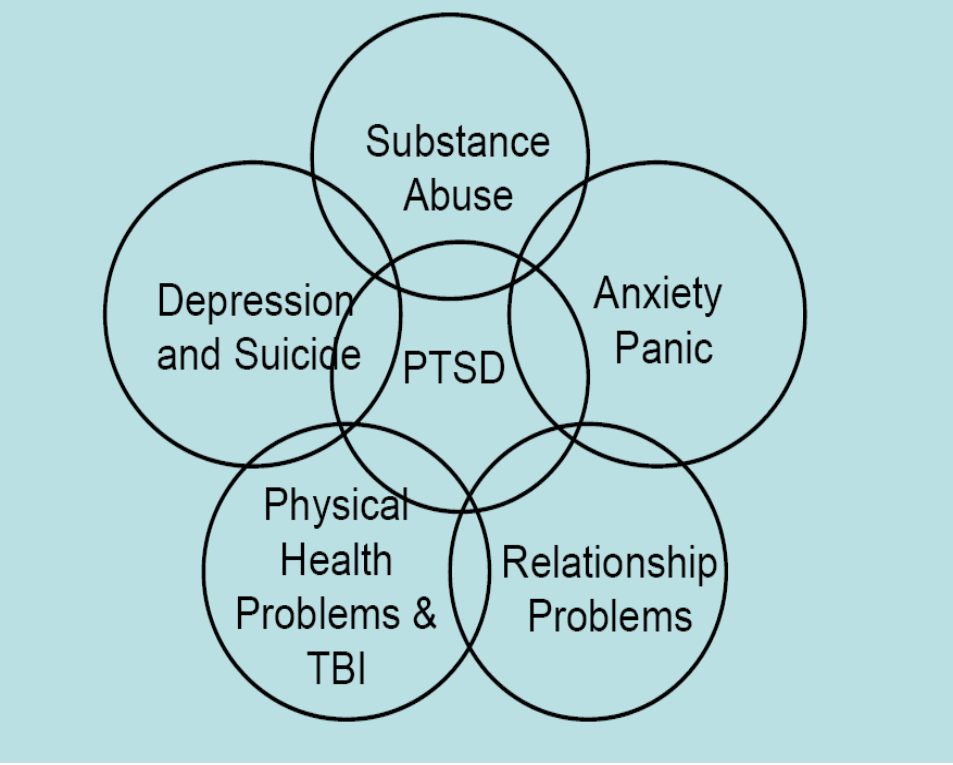
What is Post Traumatic Stress Disorder (PTSD)

The U.S. Army Medical Department defines PTSD as "an anxiety disorder associated with serious traumatic events and characterized by such symptoms as survivor guilt, reliving the trauma in dreams, numbness and lack of involvement with reality, or recurrent thoughts and images."[28] Although similar, a 2006 United States Government Accountability Office Report defines the parameters that help delineate PTSD from another similar, but less serious condition—combat stress. In this definition of PTSD it notes that

> PTSD can develop following exposure to combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. People who experience stressful events often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. These symptoms may occur within the first 4 days after exposure to the stressful event

> or be delayed for months or years. Symptoms that appear within the first 4 days after exposure to a stress event are generally diagnosed as acute stress reaction or combat stress. Symptoms that persist longer than 4 days are diagnosed as acute stress disorder. If the symptoms continue for more than 30 days and significantly disrupt an individual's daily activities, PTSD is diagnosed. PTSD may occur with other mental health conditions, such as depression and substance abuse.[29]

Although both are adequate definitions, it is important to understand PTSD from the perspective of those who have been in combat. "PTSD as a result of combat is almost always associated with various physical reactions, emotions, and perceptions that do not conform to a neat diagnosis."[30] Soldiers often exhibit other problematic symptoms that are commonly associated with PTSD such as depression, anxiety and panic disorder, and disorders associated with alcohol or substance abuse of both the legal and illegal nature.[31] The figure below depicts the overlapping correlation that PTSD has with other behavioral health issues.



[32]

The four symptoms most commonly associated with PTSD are:

1. Reliving the event (hearing a car backfire, seeing an accident, or hearing news of an event that brings back bad memories),
2. Avoiding situations that are reminders of the event (not watching the news that may have reports on events "i.e. the war", avoiding locations that have smells "diesel fuel, trash/waste" that trigger bad memories),
3. Feeling numb (not interested in activities previously enjoyed, unable to remember details or parts of the tragic event or unable to talk about it, unable to have positive feeling/relationships with others), and
4. Feeling keyed up or hyper-arousal (easily become angry or irritable, feelings of hopelessness, shame, or despair, employment issues)[33]

Impacts of Post Traumatic Stress Disorder

The events that Soldiers experience while deployed such as extensive separation from family and friends and the possible exposure to traumatic situations often create conditions that make it difficult for them to adjust back to civilian life without significant challenges. Unfortunately these challenges extend beyond the Soldier and impact their family; "there is usually a 'honeymoon' phase shortly after demobilization, but honeymoons come to an end. You and members of your family have had unique experiences and have changed".[34] The expectations of Soldiers and their families can be very difficult during the "honeymoon" period. Situations that routinely impact this process include:

- Unresolved issues prior to or as a result of deployment resulting in separation or divorce,
- Significant injury or death of a family member or close friend during the deployment,
- Failure to recognize and accept changes within the dynamics of the family,
- Unexpected debt resulting from poor budgeting or excessive spending that is impacted by an inequality between civilian and military pay resulting in unexpected debt issues; and
- Employment issues relating to unemployment, underemployment, or personal fulfillment.

Any of the above circumstances compounded by behavioral health issues stemming from deployment may adversely impact the transitioning process for Soldiers and families. Research

from the Vietnam era shows a significant increase in marital problems and family violence in Soldiers with PTSD when compared with those who did not. It is also found that their children also experienced more behavior problems. Although this cause and effect is not exactly known, it may be that

> those suffering with PTSD have a hard time feeling emotions. They may feel detached from others. This can cause problems in personal relationships, and may even lead to behavior problems with their children. The numbing and avoidance that occurs with PTSD is linked with lower satisfaction in parenting.[35]

A Soldier with symptoms of PTSD may exhibit "negative coping" behavior in attempting to deal with problems in an unhealthy or harmful way. For quick resolution or to mask unbearable symptoms, the Soldier may block memories and the associated feelings or work over-time to avoid dealing with issues. In addition a Soldier may avoid others, remain in a state of hyper arousal, or exhibit anger and violent behavior. Soldiers may also participate in dangerous activities or self-medicate through substance abuse.[36]

Individuals suffering from intrusive memories or dreams often rationalize their self-medication by alcohol consumption as being an effort to relieve the pain or to sleep. The National Center for PTSD reports the following correlation, "People with PTSD are more likely than others with the same sort of background to have drinking problems. By the same token, people with drinking problems often have PTSD."[37] Unfortunately, the use of alcohol plays an adverse role in the behavior of individuals with PTSD and can greatly impact their ability to have stable relationships with others — spouse, children, and friends. The suffering individual my feel that alcohol to the level of intoxication is providing relief, but contrary to this it actually compounds some PTSD symptoms such as "numbing of your feelings, being cut off from others, anger and irritability, depression, and the feeling of being on guard."[38] The combination of PTSD and alcohol may further impede the Soldiers ability to reintegrate by creating other

physical and mental issues such as panic, mood, attention, addiction, physical pain, and other illness problems.

Treatment of Post Traumatic Stress Disorder

Failure to receive treatment for behavioral health issues may be attributed to several different reasons. The Soldier may be in denial that there is a problem or be unable to see that his problems are stemming from his own behavior towards others. The Soldier may refuse to surrender because of a perceived notion that a Soldier is strong; and that asking for help is a sign of weakness that may hinder career progression. Finally, it may be the inconvenience of the treatment facility location or the expense involved in either dollars and/or time away from employment. A statement in the MHAT sums up these reasons in this way:

> There are real and perceived barriers to seeking and accessing care for mental health disorders among military members. These barriers include shortages of mental health professional in some areas and the social and military stigma's associated with seeking or receiving mental health care.[39]

In a briefing at the Association of the U.S. Army annual meeting, Richard Burch, Command Sergeant Major of the Army National Guard stated that "Soldiers who faced mental health issues in the past may have been hesitant to ask for help, because of a fear of being stigmatized or suffering from other adverse effects, such as not being promoted or being blocked from leadership positions."[40] The National Guard recently implemented the "New Norm" policy to address the "stigma" or "stereotype" preventing Soldiers from seeking or receiving help. The "New Norm is the expectation that our Soldiers, families and employers speak up and ask for assistance when they face a challenge that they cannot resolve themselves."[41] The support and effort of command and leadership to remove barriers to care may make it easier to obtain treatment and encourage earlier treatment for PTSD. Studies of PTSD suggest that early treatment is of significant value and may reduce the possibility of symptoms worsening, reduce

the negative impact on relationships with the family, and reduce the impact that PTSD can have on physical health.[42]

In regard to the negative impact of stigma Vice Chief of Staff of the Army, General Chiarelli, in an interview with Frontline, emphasizes, "Stigma's something we need to attack, we need to teach soldiers the hidden wounds of war are as serious as those that you can see."[43] In 2009, General Chiarelli directed the implementation of guidelines outlined in MILPER Message 09-295 "Commander and Leader Responsibilities–Removing Stigma". The message states that "all Raters will discuss with Rated Officers and NCOs the importance of their support of behavioral health goals during initial evaluation report performance counseling."[44] The message further states that all rated Officers and NCOs "will have performance objectives identifying their support of behavioral health documented on DA Form 67-9-1, Officer Evaluation Report (OER) Support Form; DA Form 67-9-1A Development Support Form; or DA Form 2166-8-1, NCO Evaluation Report (NCOER) Counseling and Support Form."[45] A sample of objectives that could be placed on these documents includes:

OERs:

- Ensure all of my officers and NCOs keep a watchful eye on their Soldiers' behaviors to quickly identify deviations and/or those requiring psychological counseling or other care.
- Emphasize to my Soldiers that my open door policy is available for them.
- Remove the stigma associated with Soldiers seeking help by communicating the Army's policy to my Soldiers and admonishing any Soldier who ridicules or ignores a fellow Soldier in need of behavioral health assistance.
- Seek the guidance of professionals if I have concerns about changes in a Soldier's demeanor and escort the Soldier to a healthcare facility, if needed.[46]

NCOERs:

- Inform my Soldiers about the behavioral health website where assistance facilities are located.
- Implement a buddy awareness system and provide a contact card to each of my Soldiers.

- Meet with, talk with, and listen to Soldiers who appear to have behavioral health issues.
- Always be aware of my Soldiers' behavior and available to them.[47]

In follow-up to the guidance outlined in the MILPER Message, the National Guard Bureau issued a memorandum "Leadership Requirements in Support of Behavioral Health Goals (ARNG-HRH Policy Memorandum #11-002) in February of 2011 providing similar guidance stating:

> All raters will review and comply with reference 1a, which states, among other things, all raters will discuss the importance of providing positive support of behavioral health goals during initial evaluation performance counseling with all rated Officers, Warrant Officers, and NCOs. All rated individuals will document comprehensive fitness performance objectives on their support on DA Form 67-9-1, OER Support Form, or DA form 2166-8-1, NCOER Counseling and Support Form. Comprehensive fitness objectives should include goals within each of the following dimensions: physical, emotional, social, family, and spiritual.[48]

Significant research to determine the most effective treatments for PTSD is on-going. The National Center for PTSD indicates that "Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), and Selective Serotonin Reuptake Inhibitors (SSRIs) have the best evidence for treating PTSD."[49] In addition to these methods, other treatments include group therapy, brief psychodynamic psychotherapy and family therapy.

Cognitive Behavioral Therapy (CBT), is a method of psychotherapy or counseling where a therapist facilitates one-on-one counseling sessions once a week over a period of several months using Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) therapy. Both CPT and PE therapies encourage individual's remembrance of traumatic events while helping to develop coping strategies to deal with the distressing thoughts and feelings. The four main parts of the CPT strategy are:

- PTSD symptom and treatment education,
- Awareness of thoughts and feelings,
- Challenging thoughts and feelings, and,

- Understanding the common changes in beliefs brought about through trauma.[50]

The four main parts of the PE strategy are:

- Education on symptoms and treatment,
- Breathing exercises in relaxing and managing distress,
- Practice in safe settings to reduce distress and to discontinue avoidance; and
- Gaining control over feelings by talking through the trauma.[51]

Along with the one-on-one sessions that the individual will have with their therapist, both treatment processes also include a series of practice assignments that the individual must complete independently.

Eye Movement Desensitization and Reprocessing (EMDR), is another psychotherapy treatment where the therapist with the assistance of another individual (tapper) combine hand movements and tapping in an effort to stimulate rapid eye movement in the individual allowing the brain a chance to relax and work though traumatic memories. Susan Rogers, Psychologist with the Department of Veterans Affairs notes,

> The idea behind EMDR is that PTSD symptoms are really a matter of incompletely processed experience. Your brain is designed to take everyday experiences, sort them out, store the useful parts, and get rid of the part you don't need. When a trauma happens, some people get kind of hung up and don't complete the process…The eye movements help people relax enough to think clearly about the trauma, sort it out, and resolve it.[52]

EMDR also incorporates a four-part strategy that includes:

- Targeting of memory or image,
- Focusing on the target memory or image while using learned eye movements,
- Replacing positive thoughts and images after removal of distressing negative images, and
- Indentifying other physical reactions brought on by emotions associated with the target that need consideration in later sessions.[53]

Additional information on EMDR can be found at http://www.emdr.com/.

In the realm of medications, selective serotonin reuptake inhibitors (SSRIs) a type of antidepressant medication has proven to be effective for some people in treating the symptoms of

PTSD. Serotonin, a natural chemical produced in the body serves as a neurotransmitter that helps relay signals from one part of the brain to another. Some researchers "believe that an imbalance in serotonin levels may influence mood in a way that leads to depression…as well as obsessive-compulsive disorder, anxiety, panic, and even excess anger."[54] The SSRI medications are intended to raise the level of serotonin in the brain, thereby providing relief to secondary PTSD symptoms such as depression or anxiety.

South Carolina National Guard (SCNG) Family Programs – Mission and Scope

Since 9/11 over 10,900 South Carolina National Guardsmen have answered the call of our Nation in response to the Global War on Terrorism; deploying for Homeland Defense and Overseas Contingency Operations. All of the Soldiers, Airmen and their families have made significant sacrifices; twelve of them paid the ultimate sacrifice. In an effort to help Guardsmen successfully reintegrate back to civilian life, the SCNG provides services and programs through the State Family Programs Section.

The SCNG Family Programs mission "is to take care of our Service Members and their Families, making them *self-reliant* and *resilient*; to inform, plan, develop and execute all components of Family Programs."[55] Programs and services are offered to promote family growth such as Youth Camps, Soldier/Family Counseling, and Strong Bonds programs for couples. Education and life-skill training is provided through the Resilience, Risk Reduction, and Suicide Prevention (R3SP) Program. The SCNG Family Programs provides assistance during difficult times to include 24/7Emergency Support to Families and Casualty Assistance/Notification. Training Family Readiness Leaders prior to deployment and the Freedom Salute Events following deployment are also the responsibility of the Family Programs

Section. Also pertaining to deployment, the SCNG Family Programs provides Yellow Ribbon Events and the Post Deployment Seminar.

All of the services provided by the SCNG Family Programs are necessary for the growth and well-being of the military families, thereby enabling the Service Members to perform their State or Federal duties. Although all of the programs are intricately connected, the focus for the remainder of this section includes a brief overview of the Yellow Ribbon and the R3SP Programs, followed by a more in-depth description of the Post Deployment Seminar.

In 2008 David S. C. Chu, Under Secretary of Defense for Personnel and Readiness signed Directive-Type Memorandum (DTM) 08-029 "Implementation of the Yellow Ribbon Reintegration Program" providing guidance on the establishment of programs to support National Guard and Reserve Soldiers and their families during the deployment cycle. The policy states

> programs shall, as a minimum, include sufficient information, services, referrals, and proactive outreach opportunities across the United States and its territories throughout the deployment cycle for members and families to minimize to the extent practicable the stresses of military service, particularly the stress of deployment and family separation.[56]

In compliance with the guidelines, the Yellow Ribbon Reintegration Program facilitates events during the pre-deployment, deployment, and post-deployment phases to assist Service Members and their families in minimizing issues resulting from these stressful times.

Throughout the deployment cycle Service Members and their families face many challenges; with the post-deployment reintegration phase often the most difficult. During deployment there are changes in the dynamics within the family: financial decisions and continuances of household activities become the responsibility of the adult left in charge, discipline rests on the lone authority figure, and the children grow and mature over the year. The

family is a part of these subtle changes that ultimately evolve into a family with different dynamics; however, the Service Member remains suspended in the memory of the family dynamics prior to deployment. This causes the Service Member to greet post deployment with the expectation of everything being as it was; unfortunately the Service Member is also unaware of the changes within himself/herself as a result of experiences during deployment. When the expectation of everything being the same and the realty of things being different collide, it is just the beginning of the many challenges the Service Member, spouse, and family members must face — adjustment to new roles, changes to family structure, acceptance of maturity, alterations in personalities, along with financial and employment issues.

As part of the Yellow Ribbon Reintegration Program, SCNG conducts a Family Reunion Event 30 – 60 days prior to the Service members return to prepare families for the adjustment challenges with reintegration. At these events family members are provided information on financial planning and benefits available through various service partners. Reintegration education and skill development is provided through "Resiliency Briefings" to the families, seminars are conducted by Subject Matter Experts on family relationships and reconnections. Sessions highlighting critical information about TBI, PTSD, and Suicide awareness are also included.

In conjunction with the Service Members return, Yellow Ribbon Reintegration programs are held at the 30, 60, and 90-day mark in the post-deployment phase. These events, staffed by trained counselors, Chaplains, and experts in select fields cover topics appropriately timed to that period of readjustment in the family and to civilian life. Information is provided to Service Members, both married and single, and to their families. To encourage maximum participation

all activities are provided at no cost to the Service Member and their family; to include child care.

Some of the topics covered in the 30-day Yellow Ribbon Reintegration event are designed to promote emotional awareness; such as “Staying Positive” and “Spiritual Resiliency”. Other parts are geared toward growth in the family; such as “Reconnecting with My Service Member”, “Reconnecting with My Children”, and “Making Marriage Work after Deployment”. Unmarried Soldiers benefit from topics like “Adjusting Back into the Single Life”. Critical information regarding “Sexual Assault” and “Suicide Prevention” is addressed. Assistance with “Financial Planning” and “Private Consultation with Community Partners” is also made available.[57]

At the 60-day Yellow Ribbon Reintegration event the topics are devoted to those issues that tend to surface after the honeymoon period. Information provided is designed to create awareness for the Soldier and their family includes “Risk Taking Behaviors”, “Chemical Abuse”, “Anger Management”, and critical education on “Suicide Prevention” is provided. Personal and family growth is promoted through activities in building “Resiliency for Soldiers and Families” along with discussing “Financial Planning”.[58]

In an effort to assess the behavioral health of Service Members, the SCNG Yellow Ribbon Program conducts an assessment of each unit participating in the program. Although the assessment is not conducted in a formal scientific manner and no specific data/information on individual Service Members is provided, it does provide unit leadership with valuable insight to the issues their Service Members are facing. This tool is valuable in allowing unit progression comparisons to other units using historical base-line data. The assessment addresses a variety of issues impacting Service Members and families associated with the reintegration process. Some

of the questions regard general demographic conditions or changes such as marriage and employment status. Other questions focus on the Service Members abilities to successfully interact by asking if problems exist in connecting with spouse or friends, getting along with people, or anger management. Along with these are questions regarding problems with threatening harm or child abuse. Participation in high risk behaviors is assessed with questions about alcohol consumption, use of illegal drugs, gambling and legal issues. The current condition of behavioral health is also assessed through questions concerning feelings of stress, depression, restlessness, hyper arousal, sleeping issues, and intrusive memories or dreams. The Service Member is asked if he/she desires help and whether they have attended Strong Bonds. There are also questions about thoughts of suicide by the Service Member and whether the Service Member has any knowledge of another Service Member expressing such thoughts.[59]

The 90-day Yellow Ribbon event does not include the family instead focusing only on the Service Member. This event is geared towards a finalization of the first quarter of the post-deployment process within the one-year ARFORGEN "RESET" cycle. This time is devoted to inventorying equipment and closing-out administrative paperwork, and completing the Post Deployment Health Re-assessment (PDHRA) survey. Appropriate professional staff, Chaplains and military/civilian service providers are available to assist Soldiers as needed.

The SCNG recently implemented the Resilience, Risk Reduction, and Suicide Prevention (R3SP) Program in an effort to bridge the gap that exists in the National Guard in leader/supervisor "over-sight" of their Service Members having drill only two days each month. As noted in the State Adjutant General Commander's Intent:

> Intent is to promote resilience in our Guard Members and Families, develop leaders who can recognize high stress or risk factors in our ranks and mitigate them through interaction, intervention, and appropriate treatment with the end

state being a reduction in South Carolina Guard Member and Family "at risk/high risk" behaviors and suicidal actions.[60]

The R3SP program is built around a "Fire Team Concept" where each month at drill there is direct interaction and a collection of information at drill between first line leaders and Service Members. There is also an assigning of peer monitors referred to as a Soldier's "Battle Buddy" or an Airman's "Wingman". As time has traditionally been set aside each drill to maintain equipment "motor stables" through a comprehensive Preventive Maintenance Checks and Services (PMCS) program, the R3SP program will mirror this approach in maintaining Soldier behavioral health. All units will dedicate one hour each month to allow first-line leaders time to assess their Soldiers using a "Soldier/Airman Questionnaire". This information is to be used by leaders in identifying and tracking important information on the Soldiers/Airmen. Changes that may occur from one month to the next are monitored with additional follow-up if needed. The Soldier/Airman Questionnaire includes information pertaining to demographics; military rank and status for promotion; alert roster information checks; status of OER and completion of promotion qualifications; dates and locations of upcoming trainings/annual training with a discussion of any Soldier scheduling conflicts; and checks whether military ID cards and military accounts are active and working. Other more personal questions may be included in the Fire Team Leader/First Line Leader's Questions for the Soldier as indicated in the following examples:

- Soldier's Martial Status / Spouse's Name:
- Names and Ages of Soldier's Dependants:
- Soldiers Employment Status / Job Title / Length of Employment / Address of Employer:
- Does the Soldier have any on-going medical readiness issues? Are there any with his or her immediate Family?
- Does the Soldier have any on-going Financial Problems? Are there any with his or her immediate Family?[61]

A State and Major Subordinate Command level R3SP Council is in place to sustain the Commander's Intent and the integrity of this program. The State Council includes representatives of the command, medical and mental health staff, and Chaplains to include the Deputy Adjutant General, State Command Sergeant Major, State Chaplain, Deputy State Surgeon, and Director of Family Programs and Psychological Health. Training and implementation of the program is currently underway so feedback on program status is not available at this time.

Although all of the programs and services offered by SCNG Family Programs provide valuable resources to Service Members and families dealing with a variety of issues to include those related to deployment, the remainder of this paper is devoted to a program initiated in 2006 which offers a unique approach to providing assistance to Service Members returning from deployment. The program, the Post Deployment Seminar (PDS) represents the success that can be obtained when a *vision, focus of effort* and a *sense of cooperation* is combined to address a critical need — Service Member and Family care.

Creative Partnership – Post Deployment Seminar

> Fundamentally, the most effective therapies for PTSD involve telling the story of the traumatic events in one way or another so that they become more tolerable and bearable. Storytelling is an important part of what it means to be human, and there's nothing more powerful in alleviating suffering or distress than sharing what's happened with someone you trust and respect and you feel understands and cares about you. The important take-home message is that telling your story can help a great deal in the transition home from combat.[62]

The Service Members ability to tell his/her story and hear other Service Members share similar experiences is a critical component of a PDS. The PDS is a product of a unique and effective partnership between the South Carolina National Guard and the South Carolina Law Enforcement Assistance Program (SCLEAP). The South Carolina Highway Patrol initiated the

partnership following the suicide of a State Trooper who had recently returned from a deployment to Iraq. This tragic event magnified the need for a program that law enforcement officers returning from deployment with the military or as contractors could attend to assist them in reintegrating back into civilian life. In 2005 National Public Radio (NPR) aired a story "Guard Suicide Highlights Risks for Returning Troops"[63] with accompanying audio noting the tragic loss of the South Carolina State Trooper and the difficulties that many Guardsmen face with reintegration. The link to this story is at:

http://www.npr.org/templates/story/story.php?storyId=4668346&sc=emaf

A brief description of the South Carolina Law Enforcement Assistance Program and of the Post Critical Incident Seminar "PCIS") that it administers provides insight to the connection as to how this successful partnership was created. SCLEAP is an assistance program serving all employees of four major law enforcement agencies in South Carolina; its primary mission is to assist law enforcement officers who have directly experienced or been significantly impacted by the death or serious injury of another law enforcement officer or to an innocent by-stander resulting from of a shoot-out, vehicle accident, or hostage situation. In addition to line-of-duty incidents, assistance is routinely provided to employees and immediate family following fatal accidents or illness, to include suicide. An informative twenty-eight minute video on the PCIS Program is available at this site **View the video**[64]**,** and other programs and services offered by the SCLEAP can be found at the following link: http://www.scleap.org/.

The SCLEAP administers Post Critical Incident Seminar (PCIS) in assisting law enforcement officers in dealing with issues resulting from significant or traumatic events. The PCIS program in South Carolina is modeled after a program developed in the early 1980's by the Federal Bureau of Investigations (FBI). Although modeled after this program, it has evolved

through the "Crawl-Walk-Run" phases over the last eleven years in response to seminar participant comments and lessons learned in order to meet the needs of the agencies and officers it serves. The success of PCIS as measured by positive feedback from participating officers and supervisors reporting positive changes in many of these officers, the PCIS program is accepted and supported by the leadership of the agencies that fund SCLEAP. As further evidence of the programs perceived benefit, the South Carolina Highway Patrol requires all Troopers involved in specific types of incidents to participate in a PCIS. The Standard Operating Procedure (SOP) of mandatory attendance to PCIS events helps diminish apprehension of an officer concerned with perceived "stigma". PCIS programs are normally held every six months and through an informal agreement with the North Carolina Highway Patrol, officers from either state may attend a program hosted by either organization.

Critical components of any program are the resources needed to plan, implement and sustain continuity of operations. Although SCLEAP receives funding from its host agencies to help fund PCIS and other program events, budget reductions due to the economic downturn have significantly strained these resources. The establishment of the Law Enforcement Chaplaincy for South Carolina (LECSC) was created in part to offset funding shortages and to allow SCLAEP greater flexibility to fulfill its mission. The mission of LECSC is "a 501c3 organization, governed by a Board of twelve volunteers, which exists solely for the support of the law enforcement community and crime victims in South Carolina."[65] As a 501c3 organization, LECSC is able to receive tax deductable monetary donations and donations of monetary value to supplement other funding sources. This funding source has enabled SCLEAP to conduct and fully fund recent PCIS events.

Success of the PCIS programs in the Carolinas has been observed by Georgia, Tennessee, and Virginia and resulted in their interest in starting similar programs. In addition, at a PCIS held in South Carolina in 2010, representatives of the National Police from Finland, Italy and Slovenia attended a seminar as observers to gain insight into the program in an effort to determine if their organizations could benefit from a similar program. An interesting article was published in the Finnish Association of Police Organizations Journal discussing their visit to observe the program and the use of the PCIS model in the aftermath of the shooting incident at Virginia Tech University.[66] A link to the Finnish version of the article is at: http://www.spjl.fi/?1184_m=1196&s=361; a link to a Google English translation is at: http://translate.google.com/translate?hl=en&langpair=fi%7Cen&u=http://www.spjl.fi/%3F1184_m%3D1196%26s%3D361. The effectiveness of the PCIS program in meeting the needs of law enforcement officers following line-of-duty incidents served as the catalyst for the SCNG PDS.

In many respects behavioral health issues in law enforcement officers affected by critical incidents mirror those of Soldiers involved in combat. Officers and Soldiers alike express feelings of depression, anxiety, and uncontrolled anger and aggression; often resulting in self medication through alcohol consumption in an attempt to handle their problems. Unfortunately, all too often this approach only exacerbates the situation and eventually costs the officers and Soldiers their family and career.

Law Enforcement Officers and Soldiers share many similarities in their occupations and their personal characteristics. The oath to *"serve, protect, and defend"* and the desire to *"serve a cause greater than you"* is common to law enforcement officers and Soldiers; both fulfilling their oath by placing the line-of-duty ahead of their own life. In addition, Soldiers and law enforcement officers pride themselves on being mentally, emotionally, and physically

strong, capable, and resilient professionals. It is no surprise that two professions that share so many similarities also share the same critical challenges.

In developing the PCIS and PDS programs, one of the most significant challenges that leadership from both organizations face is *"stigma"*. The real and perceived stigma associated with mental and behavioral health issues can be significant barriers to law enforcement officers and Soldiers seeking treatment.

Due to the success of the PCIS program and the many similarities that law enforcement officers and Soldiers have in common, it is not surprising that the PDS model developed by the partnership is very similar to the PCIS model. The framework of PDS model and a typical event schedule include:

- Three day weekend event to accommodate the schedule of Guardsmen,
- 25-30 Soldiers and spouses per event, accommodations and meals are provided,
- Staff include Mental Health Professionals, Chaplains, and Peer Team Members; and
- Program consists of large group, small group, and individual sessions.

The schedule for the three-day event encompasses a variety of topics and activities to include:

- Day 1: The Clinical Director gives a brief history and overview of the PDS model, explains EMDR therapy and provides a presentation on "Critical Incidence Trauma". In an effort to determine the issues and concerns of event participants, the *Impact of Events Scale-Revised* assessment is administered. Following the assessment, the PDS team introduce themselves and provides a brief background on their qualifications and experience. As part of the large group discussion, select Peer Team Members give their personal testimony on the events that impacted them and the benefit they

derived from participating in a PCIS or PDS event. Following these testimonies seminar participants are encouraged to share their story.

- Day 2: The second day begins with a presentation on the "Emotional Cycle of Deployment-I". Participants break-up into small groups for a discussion with their Peer Team Members and mental health counselors, to have one-on-one counseling sessions with mental health counselors, or to participate in EMDR treatment. Groups reconvene for a presentation on "Military Relationships", followed by an informational session on "Medicine: What Helps?" led by a medical doctor. Then a "Soldier's Story about Drinking" testimony is presented by a recovering alcoholic. The day normally concludes with a Patient Advocate from The Veterans Administration (VA) discussing programs and benefits available through the VA, followed by a question and answer session.
- Day 3: The last day begins with a follow-up presentation on the "Emotional Cycle of Deployment-II". Participants break up into small groups with their Peer Team Members and Counselors for further discussion, counseling and EMDR therapy. Then the large group reconvenes and delves into a presentation on "The Search for Meaning of Life" led by a Chaplain, followed by a video titled "Overcoming Adversity – Charlie Plumb". The event closes with an informal Round-Robin discussion session followed by an Event Evaluation.

Seminar participants generally provide positive comments on all aspects of the program; however, one area in particular that is highlighted is the Eye Movement Desensitization and Reprocessing (EMDR) sessions. There are normally five to six EMDR trained counselors available to assist Soldiers at each PDS event. Each Small Group team is assigned two

counselors to include an EMDR therapist and a Peer Team Member. In addition to conducting one-on-one EMDR sessions, the counselors are available to facilitate group discussion and one-on-one counseling sessions.

It is important to note here that there is a cost to conducting a PDS event. Costs associated with the event include staff and participants lodging, meals and travel, as well as staff compensations and meeting space rental. A typical PDS includes sixty staff and participants for the three day event. PDS events are hosted in commercial or government facilities that offer accommodations conducive to personal growth and appealing to the Soldier and their spouse. Availability of government facilities with suitable accommodations are generated limited and usually in high demand. Facilities normally used by Soldiers for other purposes may be used, but to minimize situations that may make the Soldiers feel uncomfortable (stigma), consideration should be given to scheduling the event at a time when other events are not scheduled. For the convenience of the reader, a cost breakdown of the resources needed to conduct the two most recent PDS events (2010-2011) is provided:

Resources	Hotel/Conference Center	SCNG Facility
Professional Staff	*$14,500 / **$6,750	*$14,500 / **$6,750
- Ph.D. / Clinical Director / EMDR Provider	1	1
- Psy.D. / Clinical Staff / EMDR Provider	1	1
- Ph.D. / Clinical Staff	1	1
- LISW / Clinical Staff / EMDR Provider	1	1
- MA / Clinical Staff / EMDR Provider	3	3
- MD /Ed.D. / Presentation on Medicine	1	1
Lodging	$7,590	$7,840
Meals	$3,750	$2,675
Meeting Space	$3,500	--------
Travel	$1,600	$1,930

Printing Costs	$75.00	$25.00
Total	*$31,015 / **$23,265	*$26,970/ **$19,220

The cost noted above for professional staff is displayed in two ways, *true cost and **actual costs. The *true cost reflects the monetary value of these staff members if their services were being compensated. Of the eight professional staff members that supported these events, only two were compensated, the others provided their services at no cost except for expenses (lodging, meals, and travel). Professional staff willing to volunteer their services for a program of this nature goes well beyond monetary savings; it reflects a commitment on their part to help others who have made a significant sacrifice to a greater cause and their sincere belief that the services offered in the program provide positive and effective benefit.

Written comments recorded on end-of-event evaluations from police officers, Soldiers and spouses participating in either a PCIS or PDS event; indicate the seminar is successful in providing an environment that is conducive to allowing participants to accomplish the following:

- Openly discuss challenges of reintegration issues with fellow Soldiers, Peer Team Members, and mental health professionals in large and small group discussions and one-on-one sessions.
- Realization that they are not alone in dealing with issues resulting from a deployment or the line-of-duty incident(s),
- Realization that their response to these incidents is a normal response to an abnormal situation,
- Realization that their actions and behaviors impact others (family, friends, employment); and

- Understand that there are additional resources available to help them address specific issues.

Participant written comments following a recent PDS event provide anecdotal evidence of the benefits of the PDS:

> ▪ The group discussions have been the most influential part of this weekend. Even though I fully trust and feel comfortable around my fellow deployed soldiers, it's still hard to admit to having a problem. If it weren't for the testimonies of the peer counselors and other soldiers, I would not have been able to speak out with my problems. The small group discussions were incredibly meaningful to me, being able to express my problems and feelings, while someone else interpreted them, really made the difference. I personally know that this weekend has placed a young soldier back on the right path, and in my opinion, saved his life. Thank you.[67]
>
> ▪ I really enjoyed this program. It was the most beneficial program I have experienced offered by the military. It is not just a "check the block – here are some references" kind of program. The people are really genuine and dig deep to find out what is really going on and then target the appropriate issues as individuals and not just as a whole. At the same time, being able to relate to other people with similar issues is a big relief in itself. Also, this group of professionals really helped me understand what was causing the issues and how to make them better. Hands down, this was a great thing and could be beneficial to so many soldiers and save so many lives. Great job.[68]
>
> ▪ This seminar has been better and more effective than any other redeployment or post-deployment briefings. It is very intimate being in a small group and with people who are going through the same things you are. I would highly recommend this for the future. This seminar not only helped me with issues I've had since returning home from Iraq, but also issues, pain and guilt I've been carrying around from an event that happened during my childhood. Also, being here as a unit brought us closer together and made our bonds with each other stronger. This is the first seminar I've been to since being home that I truly felt cared for and that these professionals were here to truly help us. For the first time I felt that we were not a box that needed to be checked off. This seminar is a wonderful thing, and I believe it should continue to be able to move forward and help other soldiers. Great seminar and thank you to all the men and women who made it possible and helped.[69]
>
> ▪ Personally, I am leaving this seminar in a much better emotional state than when I arrived. EMDR sessions with — — were exceptionally helpful for me. I feel that I am going home with a solid plan of action and most importantly hope.[70]

In addition to comments received immediately following an event, positive comments received in follow-up contact (e-mail, phone calls and face-to-face in some situations) with participants provides further credence that the events are successful in helping participants deal with issues they are experiencing. The benefits noted by Soldiers attending PDS events and from the leadership of the units represented by these Soldiers provide similar feedback of that noted by the law enforcement community in regards to a PCIS event. However for research purposes and in an effort to determine if the positive results that are reported by participants of a PDS can be validated, a formal assessment of the program is required.

> Program Evaluation can play an important role in the development and maintenance of new programs by providing: (1) valuable feedback, not otherwise available to program developers, and (2) accountability, and therefore legitimacy, to higher-level administrators. It may thus be of value, as we begin to provide services to a new generation of war-zone veterans from the Iraq conflict, to implement program evaluation strategies early in the course of program development.[71]

PDS Assessment Methodology: "Blue Print"

Offered below is a sample "blue print" for a methodology that may be used to assess programs. The outlined approach may be applied to the assessment of the Post Deployment Seminar.

1. Identify and define the problem:

SCNG Soldiers and Airmen including those deployed to Iraq, Afghanistan, and CONUS (NCR missions) are experiencing significant reintegration issues when transiting back to family and civilian life. Many exhibit symptoms commonly associated with PTSD. These symptoms include anxiety, panic disorder, depression, alcohol abuse, and abuse of legal and illegal substances. These conditions when combined with concerns related to un-employment or under-

employment create stress on the Soldier and the family, manifesting in high risk behavior, marital and family discord, suicide ideation, and suicide.

2. Formulate the Hypothesis / Null Hypothesis:

Hypothesis: The application of the PDS provided by the SCNG will reduce intrusive thoughts, anxiety, and depressive feelings among Soldiers returning from deployment. Three psychological instruments including the Impact of Events Scale-Revised, Beck Anxiety Inventory, and Beck Depression Inventory-II, are used to measure change in these emotions.

Null Hypothesis: There will be no significant pre-test and post-test difference in intrusive thoughts, anxiety, and depressive feelings between the experimental and control groups.

3. Construct the experiment:

The experimental design shall include:

- Control and Experimental Groups: The experimental group will receive the treatment in the form of a PDS. The PDS is the independent variable and is hypothesized to explain change in the dependent variable. The PDS is expected to reduce and/or mitigate symptoms associated with Soldier reintegration. Participants in this study will be the result of a Convenience Sampling. The SCNG will select a military unit that recently returned from deployment — minimum of ninety-days to one year and completed all Yellow Ribbon requirements. All Soldiers within a unit will be solicited for inclusion in the study through a letter presented by way of the SCNG Family Programs. This letter will describe the study in enough detail as to facilitate informed consent. It is anticipated that the response rate to this solicitation will be 90%, providing an N of 55. Study participants will be stratified by age, race, rank, marital status, and employment status.[72] Study participants will be asked to self-

report this data by way of a self-administered survey instrument included within the original solicitation/consent letter. Using a random draw, participants within each stratum will be segregated into two groups, either the experimental or control group. The following demographic break-downs are recommended stratums in the selection process:[73]

Age	Military Rank	Race	Marital Status	Employment Status
18 - 24	Junior Enlisted	White	Married	Employed
25 – 29	Junior NCO	Black	Single	Unemployed
30 - 39	Senior NCO	Hispanic		
≥ 40	Officers	Other		

- A research design embedding a pretest/posttest with a stratified then random assignment of subjects into experimental or control groups provides for greater control of Internal Validity. Internal Validity increases the likelihood that any change in the control and experimental group is related to the experimental treatment rather than other extraneous variables.[74] Random assignment of subjects into either the experimental or control group helps to control for self-selection bias. A control group helps to control for errors caused by history, test practice and maturation. The pretest/posttest design ensures the small sample-size, randomly assigned groups are similar, but may influence the outcome through test practice and sensitivity to the experimental purpose. The pretest will be used as a covariate in the statistical analysis to control for error and reduce internal invalidity. The random assignment of volunteers from stratums into the experimental and control groups reduces internal invalidity caused by experimental mortality (dropping out of the study) to the loss of

subjects prior to the conclusion of the experiment by allowing for re-equalization of groups by removal of subjects within matching stratums. To control for instrumentation error the instruments, measurement methods, and administrators will be standardized and the same for both groups. A briefing by a mental health professional to all study participants will address the importance of the research, the intentions of providing the program to all participants, and the necessity to refrain from conversation or any exchange of information about participation will control for design contamination, social threats, imitation of treatment, compensatory rivalry, and resentful demoralization so that any observed change may be attributed to the treatment effect. Compensatory Equalization of Treatment is controlled by ensuring that a trained and professional staff will conduct the assessment according to the recommended guidelines and will maintain the standards of the experimental design.

- The effective application of the Pretest-Posttest Control Experimental Design method also ensures greater control over External Validity. External Validity is the ability to generalize the observed effect to similar populations, settings, treatment variables, and measurement variables. The experimental design helps control Differential Selection by randomly assigning subjects into the experimental and control groups thereby allowing the findings to be generalized to the sample population. External invalidity may be increased due to the pretesting as well as experimental awareness making subjects more sensitive to the experimental variable and unrepresentative of the population.[75]
- An initial briefing of the Soldiers should be held to advise them of the purpose of the assessment, the voluntary nature of their participation and there option to elect to stop

participation at anytime during the assessment. The Soldiers should also be advised that information obtained as part of the assessment will remain confidential and be controlled by appropriate measures/personnel as determined by the SCNG.[76] Soldiers should sign an "Informed Consent of Participants" form as prescribed by the U.S. Department of Health and Human Services, Protection of Human Subjects, 45 CFR of §46 (2005). See Appendix A "**Post Deployment Seminar Soldier Briefing**".

- All Soldiers should complete the same assessments tools/inventories. The assessments should be conducted at the same time interval (initial assessment, 30 and 90-day follow-up assessments), in the same order, and administered by qualified Mental Health Professionals as determined by the SCNG.
- Recommended assessment tools/inventories and a brief description of each tool:

Impact of Events Scale-Revised:

- Authors: Daniel S. Weiss, Ph.D. and Charles R. Marmar, MD.
- Purpose: In general, the IES-R (and IES) is not used to diagnosis PTSD; however, cutoff scores for a preliminary diagnosis of PTSD have been cited in the literature.
- Description: The IES-R is a 22-item self-report measure that assesses subjective distress caused by traumatic events. It is a revised version of the older version, the 15-item IES (Horowitz, Wilner, & Alvarez, 1979). The IES-R contains 7 additional items related to the hyper arousalsymptoms of PTSD, which were not included in the original IES. Items correspond directly to 14 of the 17 DSM-IV symptoms of PTSD.
- Scoring: Respondents are asked to identify a specific stressful life event and then indicate how much they were distressed or bothered during the past seven days according to a "difficulty" listed. Items are rated on a 5-point scale ranging from 0 ("not at all") to 4 ("extremely"). The IES-R yields a total score (ranging from 0 to 88) and subscale scores can also be calculated for the Intrusion, Avoidance, and Hyperarousal subscales. The authors recommend using means instead of raw sums for each of these subscales scores to allow comparison with scores from the Symptom Checklist 90 – Revised (SCL-90-R; Derogatis, 1994).[77]

Beck Anxiety Inventory:

- Author: Aaron T. Beck.
- Purpose: Designed to discriminate anxiety from depression in individuals.
- Description: The Beck Anxiety Inventory (BAI) was developed to address the need for an instrument that would reliably discriminate anxiety from depression while displaying convergent validity. Such an instrument would offer advantages for clinical and research purposes over existing self-report measures, which have not been shown to differentiate anxiety from depression adequately.
- Scoring: The scale consists of 21 items, each describing a common symptom of anxiety. The respondent is asked to rate how much he or she has been bothered by each symptom over the past week on a 4-point scale ranging from 0 to 3. The items are summed to obtain a total score that can range from 0 to 63.[78]

Beck Depression Inventory - 2nd Edition:

- Author: Aaron T. Beck.
- Purpose: Designed to determine presence and severity of symptoms of depression.
- Description: The Beck Depression Inventory-Two (BDI-II) is a 21-item self-report instrument intended to assess the existence and severity of symptoms of depression as listed in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV; 1994).
- Scoring: Each of the 21 items corresponding to a symptom of depression is summed to give a single score for the BDI-II. There is a four-point scale for each item ranging from 0 to 3. On two items (16 and 18) there are seven options to indicate either an increase or decrease of appetite and sleep. Cut score guidelines for the BDI-II are given with the recommendation that thresholds be adjusted based on the characteristics of the sample, and the purpose for use of the BDI-II. Total score of 0 -13 is considered minimal range, 14 -19 is mild, 20 – 28 is moderate, and 29 – 63 is severe.[79]

4. Analysis and Conclusions:

The software package provided by Statistical Package for the Social Sciences (SPSS) can be utilized to analyze the data from the experiment to determine if the difference in the means of the experimental group and the control group is statistically significant.[80]

Analysis of Covariance (ANCOVA) is the best method to use with gain scores when there is a pretest and posttest score. Gain scores are calculated by subtracting the pretest from the posttest. When using the ANCOVA procedure with gain scores, the pretest scores become

the covariate, resulting in a more powerful test in determining if there is a significant difference in gain scores. This statistical test reduces the error variance and eliminates systematic bias. Since the recommended experimental design of random assignment of subjects to groups already controls for systematic bias, this method will help to reduce the error variance. Another reason that the ANCOVA is the best statistical test when looking at gain scores is that when some of the assumptions about scores does not hold true, modifications can be made in ANCOVA which may lead to the appropriate analysis.[81]

The ANCOVA is a powerful tool to use in testing significance of residual scores. Pretest scores can be used to predict posttest values using a simple regression model. When the predicted posttest value is subtracted from the actual posttest score it results in a residual score. There is a correlation between gain scores and pretest scores, but this is not so with residual scores. When the "pretest scores" variance is larger than the "posttest scores" variance then there is less error with residual scores than with gain scores.[82]

Analysis of Variance (ANOVA) is a statistical test that partitions the total variance into various groups to determine if the means of two or more groups are significantly different. ANOVA and the *t*-test for independent samples and the *t* -test for dependent samples produce the same results when comparing the means of only two samples. ANOVA, however, eliminates the possibility of committing a Type 1 Error that might result by doing multiple two sample *t*- tests. The ANOVA is used to determine if the means are significantly different by comparing the variances. The variance is the sum of squared deviations from the mean divided by the number in the sample size minus one. ANOVA may be used to partition the total variance into variability within-group and variability between-groups to determine the significance of the mean differences. [83]

The Factorial ANOVA is a statistically powerful test that may be used to partition the total variance into with-in group variability, between-group variability, and variability due to a stratum. Using a between-within design, the ANOVA can be used to investigate if there is a significant difference in the means by partitioning the total variance into between-groups variability and within-subjects (repeated measure) variability.[84]

A Multivariate Analysis of Variance (MANOVA) may be used to test whether the means of the three dependent variables (IES, BAI, and BDI-II) are together affected by the difference in independent variable. If the difference is statistically different, then it can be interpreted that the treatment does effect intrusion, depression and anxiety together. Because the three dependent assessments were measured three different times, a Multivariate Repeated Measure design can be used to test if there is statistical difference in the means of the three different measures of the dependent variable over-time, within group and between groups.[85]

Conclusions

Soldiers from both the AC and RC face many challenges when returning from deployment. Issues stemming from exposure to combat, extended separation from family and multiple deployments are just a few of the factors that Soldiers face during reintegration. Making reintegration even more challenging for Soldiers from the RC is the limited interaction with fellow Soldiers and limited access to medical facilities following demobilization. Once Guardsmen and Reservists return home following deployment the interaction with fellow Soldiers sharing similar experiences is normally limited to two days each month. Limited face-to-face interaction with the Soldiers and leadership they served with as their active duty counterparts may prevent detection of negative coping and mask conditions that require professional treatment. In addition the Soldiers Home-of-Record (HOR) may limit convenient

access to a VA medical facility due to distance or scheduling issues related to civilian employment.

Program offerings by the SCNG Family Programs such as the R3SP, Yellow Ribbon Reintegration Events such as the Family Reunion and Post Deployment Seminars provide valuable information to Soldiers and their spouses concerning the reintegration process, education on critical issues associated with reintegration and available benefits and resources. The PDS events provide a means of Soldier self-discovery and personal growth assisted by professionally trained individuals through valuable interactions between Soldiers and spouses experiencing similar behavioral health issues in reintegration. Written comments of participants and their leadership is evidence of the benefits of the PDS events. Reasons given by the participants for the positive impact to attending the program include the structure of the program in providing Large Group educational sessions and Small Group discussion sessions, the relaxed atmosphere, the knowledgeable and deeply committed staff, and interaction with their peers.

Funding to implement and sustain programs such as the PDS is essential. However, since the PDS is not a program of record, and therefore has no direct funding source, the SCNG is left with funding PDS through existing sources. Although the program has been well received by participants and their leadership, reduced budgets will require close scrutiny of the program to see if it provides measurable and sustained benefits. As previously indicated, all of the programs provided through the SCNG Family Programs are equally necessary in assisting our Soldiers with reintegration; and deserve funding resources to plan and carry out their mission. Likewise the PDS events need a direct resource to adequately move forward in developing and providing the program to assist all SCNG Soldiers with reintegration.

Recommendations

An orderly and controlled decompression process allowing for interaction with Soldiers having together shared the same experiences is the best way for Soldiers to smoothly transition in reintegrating back into civilian life. For this reason, the following policy recommendation is respectfully submitted. On leaving the demobilization-station, Soldiers are given a four day pass in conjunction with a weekend to return home to visit with family and friends. At pass conclusion, the Soldiers return to a centralized location to participate in reintegration activities for a two-week period. Activities should include those currently conducted at the Yellow Ribbon Reintegration 30, 60, and 90-day events as well as completion of all administrative requirements (i.e. OERs, NCOERs, and awards) while resources and personnel are readily available. In addition, access to professional staff such employment specialists to provide assistance with employment issues and mental health counselors to provide group and one-on-one counseling as needed should be made available to Soldiers. At the conclusion of this process, the Soldiers would return home to begin a 30, 60, and 90-day cycle similar to the current system to ensure success in reintegration. Providing decompression immediately following deployment in a centralized location allowing direct interaction with Soldiers having shared the same experiences and circumstances in deployment and assisted by professionals is the optimal way to monitor for early signs of negative coping or behavioral health issues requiring treatment and leads to a more successful transition into reintegration back into civilian life.

A second recommendation is for the SCNG Family Programs to evaluate the effectiveness of their informal survey currently administered at the Yellow Ribbon Reintegration 60-day event to determine its effectiveness in identifying and meeting program needs. A suggestion is made to collect base-line data by administering the tool in the pre-mobilization

process to compare with 60-day post-deployment survey data in assessing changes in the Soldier and unit. The data from the pre-mobilization assessment and the post-mobilization assessment should provide valuable insight to leaders on issues and concerns their Soldiers are experiencing, while providing guidance and direction for Yellow Ribbon Reintegration Program planning.

The SCNG should conduct a formal evaluation of the PDS event to determine if reported benefits can be statistically validated. The evaluation of the PDS program should be conducted utilizing an appropriate experimental design methodology as outlined in Section 5, South Carolina National Guard (SCNG) Family Programs PDS Assessment Methodology "Blue Print", or through a similar process controlling for extraneous variables which may influence results. An appropriate statistical analysis should be used to determine if the group means are significantly different. Analysis should include comparison of pretest-posttest means within-group and between-groups. A repeated measures analysis should also be conducted on subject's pretest-posttest means within groups. Information gained from the statistical manipulation of the strata in comparing pretest-posttest means to determine significance should provide guidance for consideration in future research.

The final recommendation is made in an effort to provide the SCNG Family Programs with another source of funds from which to draw support for existing and future programs. Recommendation for the SCNG and the National Guard Association of South Carolina to partner in establishing a 501c3 entity specifically oriented to support Soldier / Family care issues. In this way regular programs may be planned within their budgetary allocations; with funding necessary for additional programming provided through the 501c3.

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Appendix A

Post Deployment Seminar Soldier Briefing

The South Carolina National Guard (SCNG) is conducting a formal assessment of one of the programs that it provides to Soldiers who are returning from deployment. The program is the Post Deployment Seminar (PDS) and it is designed to assist Soldiers in the reintegration process. Your unit has been selected to participate in the assessment of the PDS. The PDS began in 2006 as a joint endeavor between the SCNG and the South Carolina Law Enforcement Assistance Program (SCLEAP) and is modeled after the FBI Post Critical Incident Seminar – PCIS.

The PDS is a three day event and is staffed with Peer Team Members, Chaplains, and Mental Health Professionals. The intent of the program is to establish an environment that allows you to:

- Openly discuss challenges of reintegration with fellow Soldiers, Peer Team Members, and Mental Health Professionals in large and small group discussions and one-on-one sessions.
- Realize that your response to deployment and reintegration is a normal response to an abnormal situation.
- Realize that you are not alone in dealing with issues resulting from a deployment.
- Realize that your actions and behaviors impact family, friends, and employers.
- Understand that there are additional resources available to help you address specific issues.

Your participation is voluntary and any information obtained from you will remain confidential as prescribed by the SCNG. You may choose to opt out of the assessment at any time during the process without any consequences resulting from your decision. As required by the U.S. Department of Health and Human Services, Protection of Human Subjects, 45 CFR of §46 (2005), you will sign an "Informed Consent of Participants" form.

All volunteers will be divided into two groups balanced on the criteria of age, rank, marital status, and employment status. You will be randomly assigned to one of the two groups. In an effort to maintain the integrity of the research, you are requested to avoid any discussion of the events within your group with Solders/spouses outside of the group setting. You will complete the Impact of Events Scale-Revised, Beck Anxiety Inventory, and Beck Depression Inventory-II at the beginning, the 30-day interval, and the 90-day interval during regular drill week-ends. Attendance at the PDS will be in lieu of drill with lodging, meals and travel to attend the seminar provided or reimbursed by the SCNG. It is the SCNG's intent to offer all Soldiers the opportunity to attend a PDS.

The next PDS is scheduled to be conducted on:

_____at_____.

(Date) (Location)